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John F. Schunhoff, Ph.D.
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Robert G. Splawn, M.D.
Interim Chief Medical Officer

313 N. Figueroa Street, Room 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

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February 6, 2009

TO: Each Supervisor

FROM: John F. Schunhoff, Ph.D.
Interim Director

SUBJECT: **STATUS REPORT ON KEY INDICATORS OF PROGRESS, HOSPITAL OPERATIONS, AND OTHER ISSUES RELATED TO THE TRANSITION TO THE NEW LAC+USC MEDICAL CENTER – PROGRESS REPORT #5 (Agenda Item #S-1, February 10, 2009)**

This is to provide your Board with the bi-monthly report on the status of transitioning to the new LAC+USC Medical Center (LAC+USC). This report is not a full monthly report but an interim operational report and includes additional information in response to the questions posed by your Board at the meeting held on December 9, 2008.

Census Trending (ADC includes Psychiatric & Newborn Patients)

The Average Daily Census (ADC) for the month of January 2009 was 548 out of 671 licensed beds, an estimated 80% utilization rate (82% occupancy). This is an increase from an ADC of 525 for the prior month. The census for Medical/Surgical (Med/Surg) units continues to grow with an estimated 93% utilization rate (95% occupancy) for January 2009.

Emergency Department and Admission Volume Trending

All trends are clearly indicating that the census is returning to pre-move levels. This will also be described in the Analysis of Patient Specialty Services section below.

To evaluate the census trends, we also conducted analyses of Emergency Department (ED) registration volumes, admissions from the ED, and total hospital admissions. Attachment 1 demonstrates the trending of ED registration volume with a minimal 3-6% reduction in volume for the months of October through December 2008, as compared to the same months in 2007. A similar reduction occurred in admissions from the ED in November and December 2008 as compared to the prior year. Both volumes of ED registration and admissions from the ED for January 2009, have nearly reached parity with the prior year. On average, 15.6% of the patients seeking care at LAC+USC ED are admitted for inpatient care.

The total hospital admissions in November 2008 were 41% lower than November 2007 as a result of census decompression prior to the move; ambulance diversion during the move; and necessary time to return to normal activity after the move, i.e., elective surgeries, acceptance of transfers, etc.

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In the following month, December 2008, the total hospital admissions were significantly higher but still 14% lower than December 2007. By January 2009, the total hospital admissions had recovered to within 9% of the prior year.

Medical School Operating Agreement

In a previous Board meeting, Supervisor Antonovich inquired as to the progress of implementing the physician hiring within the Medical School Operating Agreement (MSOA) that was approved by your Board in November 2008. Approximately 80% of the MSOA service agreement physician staffing is currently on board. This includes positions for the Accreditation Council for Graduate Medical Education (ACGME) Program Directors, General Medicine, Medical Specialties, Emergency Medicine, Intensive Care Unit, Psychiatry and others. There will be some positions that will not be recruited until mid-year as new graduates from various programs become available and seek positions.

Additional Information Requested

On January 6, 2009, DHS and the Chief Executive Office were instructed by your Board to report back in March on the following: 1) detailed information on the diversion process, including data on the number of ambulances and patients being diverted from Harbor/UCLA Medical Center and LAC+USC and if the diversion procedure is resulting in people being underserved; 2) progress on DHS' long-range plan to establish a central base station in order to track all ambulances; 3) analysis of patient specialty services and the actions being taken to address any census or staffing issues identified; 4) are the residents receiving the necessary training experience as required by the ACGME; 5) what is being done to evaluate the impact on residents' specialty training programs for both LAC+USC and residents rotating from other programs with regard to the inpatient training experience; and 6) plans for how the specialty beds could be utilized to serve patients other than what they were originally designed for.

Accordingly, in an effort to keep your Board informed in a timely manner, the requested update is provided below without delay.

Hospital Diversion Process

The requests and criteria for diversion are defined by DHS' Emergency Medical Services (EMS) Agency Policy, Reference 503, Guidelines for Hospitals Requesting Diversion of Advanced Life Support (ALS) Patients and is recorded in a central data base system called ReddiNet. The request for ED saturation diversion is made by the ED, from both public and private hospitals, with prior approval of the hospital administrator or designee.

Hospitals that receive patients from the 911 system may request that patients requiring ALS (critical care) and accompanied by a paramedic be diverted to other facilities. Basic Life Support (non-critical) ambulances continue to transport patients to the closest hospital regardless of diversion.

Diversion allows a hospital to request that more critical patients are sent to the next closest hospital when the ED staff and equipment are fully committed and not available. When more than one hospital in a geographic location is on diversion, the policy defines the allowed travel time for paramedics to transport to alternate hospitals. When all hospitals in a geographic area are on diversion, patients are transported to the closest facility.

In response to your inquiry about diversion at County hospitals and based on an analysis of multiple months, an average of two patients per day are diverted from Harbor-UCLA Medical Center during the period the ED is on diversion; an average of one patient is diverted from LAC+USC during the period the ED requests diversion.

Patients are not underserved as a result of diversion policies. The diversion to ED saturation policy was developed to ensure that patients arrive at facilities with resources and capability to handle them and to prevent a single facility from being overwhelmed by critical patients. In essence, this is a safety net procedure of the 911 system.

Establishment of a Central Base Station

There are several factors that are leading to the development of a Central Base Station. Currently, there are 20 hospitals, both public and private, that that are designated by DHS' EMS Agency to function as paramedic base stations with the responsibility of providing medical direction to field paramedics over the radio or telephone. In the beginning of EMS system development, there were nearly 40 of these base stations. Due to the significant financial commitment to perform this vital function, hospitals over the years have chosen to withdraw from the base station system. Therefore, DHS is concerned that resources for this function will continue to decline. In addition, such a system of multiple hospitals leads to lack of standardization, despite system policies and protocols. Finally, there is currently no central entity that can monitor the whole system in real time and provide EMS system status management.

The EMS Agency has begun an extensive process to establish a Central Base Station within the Agency to provide this online medical direction. Steps that have been accomplished include:

- Researched models of prehospital medical control.
- Indicated the direction for the establishment of an EMS Agency base station within the Trauma Centers agreements.
- Communicated with the State EMS Authority and requested a review of the EMS Agency base station proposal and interpretation of the Health and Safety Code, 1798.100 defining base stations. A meeting to discuss regulatory issues with the State EMS Authority was held January 20, 2009.
- Identified a funding source and obtained an initial allocation of positions to staff the EMS Agency base station.
- Hired a staff position to develop programmatic requirements and define phases of implementation and integration within the EMS system.
- Identified a location within the EMS Agency Coordinated Communication Center to establish the base operations.
- Initiated discussions with LAC+USC Emergency Medicine residency program to determine the feasibility of developing an education rotation for the medical residents through the base station.

Once the regulatory issues are resolved, the EMS Agency plans to move forward with a phased implementation. As stated at the Board meeting of January 6, 2009, there are existing constraints with the current paramedic communication system due to reliance on line of sight transmission. Until the Los Angeles Regional Interoperable Communication System (LA-RICS), the County's interoperable communication plan for law, fire and health, is fully implemented over the next four to five years, the plan to move communication with paramedic units to the Central

Base Station will be determined based on need and ability to establish reliable communication.

Analysis of Patient Specialty Services

Attachment 2 demonstrates the ADC trends for the specialty areas of OB/GYN, Pediatrics, ICU, Psychiatry, Jail and Burn inpatient services. The areas of OB/GYN, Pediatrics, ICU, Psychiatry and Burn services have shown an increase in census since the move to the new facility. In particular, Burn services at an ADC of 12 in January 2009 is at the highest point this fiscal year.

The initial reduction in pediatric ADC is consistent with reduction in census by all specialties as a result of the move and to date the pediatric census is consistently growing to near pre-move levels. Discussions with Children's Hospital Los Angeles (CHLA) have revealed that the decrease in pediatrics at LAC+USC has not resulted in a respective increase in ADC at that facility. This is significant because CHLA would be the most likely alternative to LAC+USC for pediatric patient care. Several measures are being taken to ensure maximal utilization of pediatric services at LAC+USC. Effective in January, LAC+USC was placed on a CHLA transfer list along with several other facilities to receive ED transfers. In addition, DHS' Office of Managed Care (OMC) is analyzing outreach activities to ensure that assigned pediatric patients are using LAC+USC services. Other options for full utilization are being explored.

The Jail service shows a slight census decrease. This unit is totally dependent on the needs of law enforcement and can not be used for any other patient population.

ACGME Program Status

A question was posed as to whether medical residents are receiving necessary training experience as required by the ACGME if there are census impacts. Residency training experience is assessed based on multiple variables including, but not limited to, inpatient encounters, outpatient encounters, didactics and scholarly activities and other measures. The minimal variance in inpatient specialty service census as described above has to date had no measurable negative impact on the stability of the residency training programs. Attesting to this, four Recent Residency Review Committee site surveys occurred, within very close proximity to the move and after the move, and resulted in highly favorable outcomes of accreditation and cycle length with the granting of several five year maximum program terms. Programs that were granted five year terms include Pediatrics, Dermatology and Urology; while the Orthopedic Hand Surgery program received a four year approval which was an increase from its previous three year approval.

Initial evaluations appear positive for the residency training, although it is still very early to determine if there is any effect from census variations. In fact, resident interviews and recruitment activities have provided highly positive feedback from candidates as a result of the outstanding improvements at the Replacement Facility.

Evaluating Resident Rotation in Specialty Training Programs

The Director of Graduate Medical Education in conjunction with the Graduate Medical Education Committee are planning intensive and comprehensive mid-cycle reviews for 17 resident training programs to evaluate and ensure quality resident training experiences. Additionally, an intensive survey of every resident training program is scheduled for May-June 2009 that includes evaluation of resident patient experience and resident procedure logs.

Specialty Bed Utilization

Assessment of ADC is conducted daily to ensure appropriate and maximal inpatient bed utilization. On January 6, 2009 admissions to the Adolescent Unit were expanded to include eligible adults when beds are available to decompress the adult Med/Surg admissions waiting in the ED. This has effectively doubled the ADC on this unit without impacting access or waiting times for adolescent patients. As previously stated, pediatric transfers from CHLA have been actively facilitated and are increasing. Other options for full utilization of specialty beds are being explored.

If you have any questions or need additional information, please contact me or Carol Meyer, Interim Chief Network Officer at (213) 240-8370.

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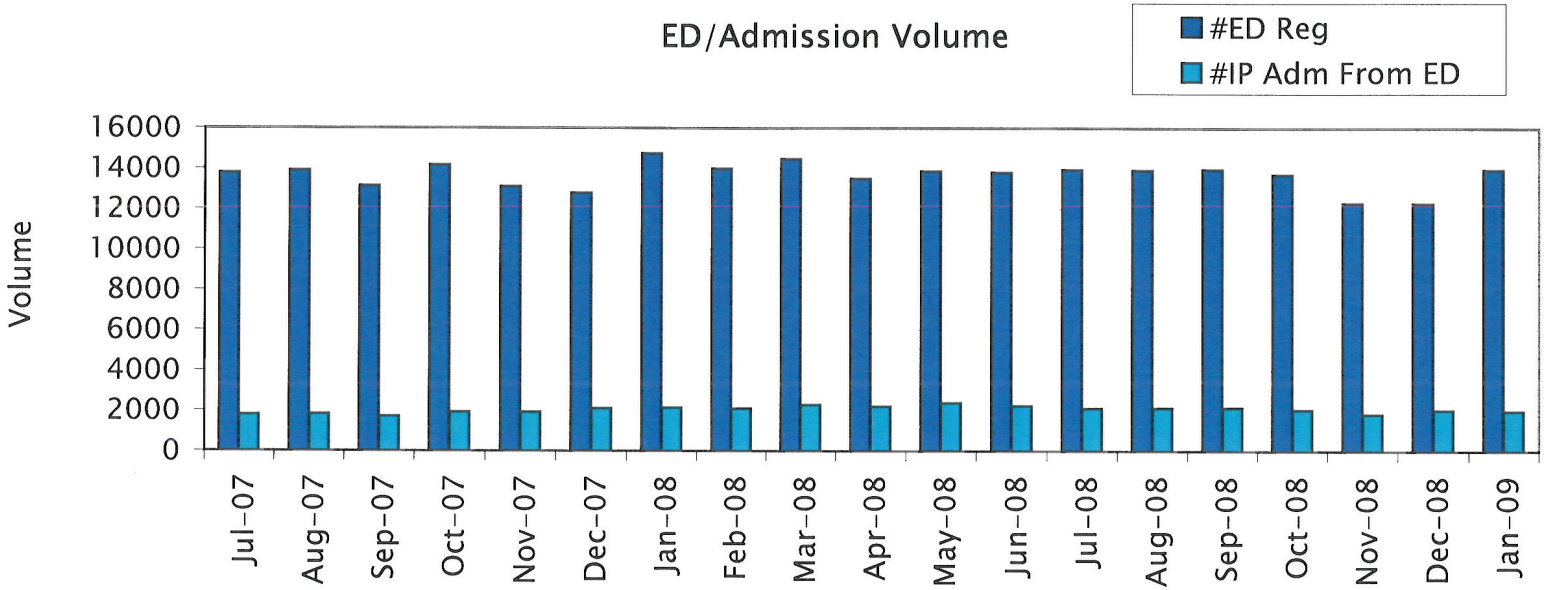
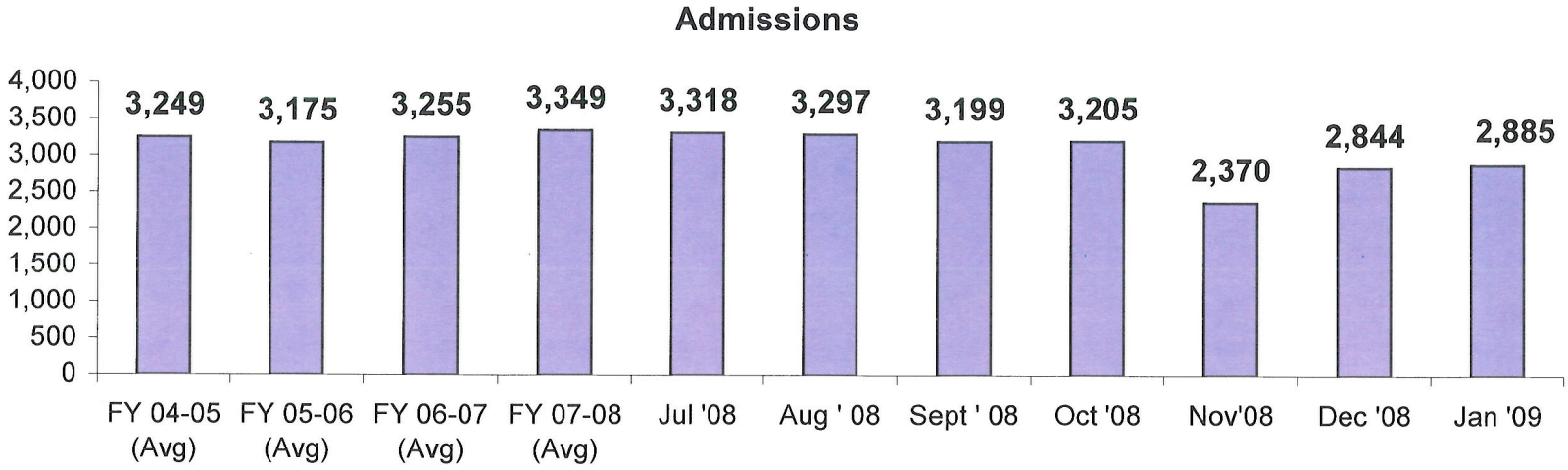
Attachments

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

Attachment 1

LAC+USC Medical Center
Workload Summary





LAC+USC Healthcare Network
Average Daily Census by Nursing Unit Subset
Jul-2008 to Jan-2009 (Med/Surg and Newborn Excluded)